8 Tchernof A, Lamarche B, Prud'Homme D, Nadeau A, Moorjani S, Labrie F, et al. The Dense LDL phenotype. *Diabetes Care* 1996;19:629-37.
9 Hokanson JE, Austin MA. Plasma triglyceride level is a risk factor for cardiovascular disease independent of high-density lipoprotein cholesterol: a meta-analysis of population-based prospective studies. *J Cardiovasc Risk* 1996;3:213-9.
10 Assmann G, Schulte H. Role of triglycerides in coronary heart disease:lessons from the Prospective Cardiovascular Munster Study. *Am J Cardiol* 1992;70:10h-3.
11 Little P. GP documentation of obesity: what does it achieve? *Br J Gen Pract* 1998;48:890-4.
12 Ashenden R, Silagy C, Weller D. A systematic review of the effectiveness of promoting lifestyle change in general practice. *Family Practice* 1997;14:160-76.
13 The prevention and treatment of obesity. *Effective Health Care Bulletin* 1997;3 (April):1-11.
14 Williamson D. Pharmacotherapy for obesity. *JAMA* 1999;281:278-80.
15 Rubins HB, Robins SJ, Collins D, Fye CL, Anderson JW, Elam MB, et al. Gemfibrozil for the secondary prevention of coronary heart disease in men with low levels of high-density lipoprotein cholesterol. Veterans Affairs High-Density Lipoprotein Cholesterol Intervention Trial Study Group. *N Engl J Med* 1999;341:410-8.

Reforming the GMC

Current proposals make a muddle of the possibilities for radical change

The consultation paper *Protecting Patients: A Summary Consultative Document*, published this week by the General Medical Council (GMC), Britain's licensing body for doctors, sets out options for reform under two main headings: the GMC's structure, constitution, and governance; and its procedures for dealing with allegations against doctors.[1] The proposed reforms follow harsh criticism from the public, government, and doctors that the GMC is, among other things, unwieldy, slow, defensive, and constrained in its powers.

The GMC currently consists of a council with 104 members, including 25 lay members. Under the GMC's preferred model for reform key decisions would be made by a new executive board of 20-25 members (60% medical and 40% lay). The board would be elected from, and accountable to, a wider council of around 80 members, equally split between medical and lay members. A lay chair would oversee the council, while a medical president would preside over the executive board.

A small board with statutory powers should enable the GMC to become more decisive and responsive. It meets the government's tests for reform: smaller more transparent bodies acting with greater public involvement.[2] It is also in line with best practice for the corporate sector[3] and with the new Nursing and Midwives Council (NMC) and proposed Health Professionals Council (HPC).[4 5]

So far so good. But *Protecting Patients* confuses the picture with three possible approaches to reform. The first is the government's favoured model of relying solely on an executive board, but a politically unwise GMC dismisses this out of hand. The other two approaches both include a board and a council. But the GMC gets caught up on arguments about the exact division of powers between the two. For example, should the council hold all the powers and delegate action to the smaller board, or should the smaller board hold those powers but be accountable to the wider council—as the GMC prefers. The trouble is that this debate distracts attention from the real need to jointly address the concerns of both government and profession. How much more asute it would have been to focus minds on how the GMC's preferred model squares government requirements with the profession's need for representation.

The second part of *Protecting Patients* outlines options for reforming the way the GMC handles complaints against doctors. The current system is criticised for being complex, creating delays, and lacking a full range of findings. To reduce duplication the GMC proposes to merge the early stages of the current procedures where decisions are made about whether the complaint should proceed and if so which procedures it should go through—health, performance, or conduct. Under its proposals, a new committee would investigate cases at an earlier stage and have greater flexibility to ensure complaints are handled in the most appropriate way.

The GMC also proposes introducing a new lower finding against a doctor—professional misconduct. This would sit alongside the existing and more substantive charge of serious professional misconduct and could be applied when serious professional misconduct is not proved. Supporters of this move argue that it could allay criticisms that doctors whose conduct is poor but not bad enough to constitute serious professional misconduct fall through the existing system.

However, this reform is neither logical nor full hearted. The fact that the new lower finding would apply only in cases where serious professional misconduct is not proved limits its application. Should it not be a charge in its own right? In addition, the sanctions proposed for this new finding may be insufficient: the consultation paper talks imprecisely of placing a reprimand on the doctor's file without proposing clear accountability for action.

At present the GMC acts as judge, jury, and prosecutor. *Protecting Patients* makes a strong case for separating prosecution and judgment. It is not only lawyers who recognise the more robust and fair approach such a separation could bring, such as improving the confidence of both the public and the profession in the work of the GMC. However, the GMC's preference for retaining both functions within its overall ambit, behind proverbial "Chinese walls," is an example of the GMC grasping a weakened version of a bold idea.

Reform of the GMC represents piecemeal change to the wider regulatory system. In places *Protecting Patients* mentions (if only in passing) the complaints procedures, annual appraisal, clinical governance, and the GMC's own creature—revalidation. It is widely acknowledged there is a need for clarity over how accountability for public protection should be shared across these complex professional and managerial systems.[6] It is not the GMC but this wider system that really protects the public—though at present it is not

BMJ 2001;322:689–90

doing so systematically. In any reform the GMC needs to be clear about its place in a wider system and establish consensus with other players in the regulatory game about how to work together.

Protecting Patients reveals a GMC that has difficulties coming to terms with this bigger picture. It does not bring the clarity and commitment needed to make the case for bold reform. Why can't the GMC do better? The answer probably lies in the paper's admission that the council is dysfunctional. In *Protecting Patients* the GMC admits that the council has in the past acted "as an unnecessary brake on the effective and timely discharge of functions and formulation of policy." We need answers to the fundamental question of why the medical profession has such difficulty overcoming a tendency to internal disagreement and stasis.

This consultation paper could have presented the profession with a well argued and coherent set of wholesale reforms. Instead, disagreements between factions of the council and the wider profession are presented as a bewildering array of possible approaches and options for change. *Protecting Patients* hides some sound radicalism among a fog of detailed arguments and alternatives. The document shows us a GMC at odds with itself: a body that seems to be trying to accommodate the conflicting demands of its different stakeholders rather than brokering clear and bold change in the interests of the public. If there was doubt that the GMC needed to reform, this consultation paper would convince even a staunch sceptic. There is just time to commit to bold choices; otherwise the GMC may not satisfy a government brimming with second term confidence.

Steve Dewar *fellow*
Belinda Finlayson *research officer*

Health Care Policy Programme, King's Fund, London W1G 0AN (sdewar@kehf.org.uk)

SD facilitated the initial meetings of the GMC governance working group (September 2000) and the first meeting of the GMC electoral reform group (January 2001) and coauthored an independent King's Fund paper commissioned by the GMC on the appropriate standard of proof for GMC hearings (November 2000).

1 General Medical Council. *Protecting patients: a summary consultative document*. London: GMC, 2001. www.gmc-uk.org/consultation/default.htm
2 Department of Health. *The NHS Plan*. London: Stationery Office, 2000.
3 Cadbury A. *Report of the Committee on the Financial Aspects of Corporate Governance: the code of practice*. London: Gee, 1992.
4 Department of Health. *Modernising regulation—the new Nursing and Midwifery Council: a consultation document*. London: Department of Health, 2000.
5 Department of Health. *Modernising regulation—the new Health Professions Council: a consultation document*. London: Department of Health, 2000.
6 Better Regulation Taskforce. *Alternatives to state regulation*. London: Cabinet Office, 2000.

Death through selfishness and failure of imagination

President Bush should lead on global warming, not retreat

In a world afflicted by murder, mayhem, and malnutrition it may seem bizarre to suggest that the worst thing to happen this year is for some words to come out of a man's mouth—but that may turn out to be so. Last week President Bush reneged on a campaign promise to regulate emissions of carbon dioxide from power stations. This is a serious setback in a world that is already failing to respond responsibly to global warming.[1] The short term effects of Bush's decision may be merely political but the long term effects are likely to be catastrophic. As usual, the worst affected will be the world's poorest, those who have contributed the least to global warming.

There are few scientists left who doubt, firstly, that global warming is occurring and, secondly, that the warming is caused mostly by emissions of greenhouse gases resulting from human activity.[2–4] The evidence may not be as strong as that linking cigarette smoking and lung cancer, but it's strong enough to make inactivity in response to the threat look like recklessness. President Bush's timing was excruciating in that it coincided with the publication of a study in *Nature* that included hard data showing the increase since 1970 in the ability of the earth's atmosphere to trap the sun's heat.[5]

The expected effects of global warming are not entirely clear, but interference with systems as complex as weather can have drastic and unpredictable consequences. Most likely are flooding, the drowning and displacement of millions, destruction of arable land causing widespread malnutrition, highly destructive weather episodes, deaths from higher temperatures, and the geographical extension of diseases like malaria.[2]

The major factor driving us all to find it impossible to reduce emissions of carbon dioxide is our "addiction" to energy. Many of us, including (probably) President Bush, know that our inability to get out of our cars, switch off our air conditioning, and forsake the products of energy hungry industry and agriculture is storing up death and misery for those who come after us, many of whom are already born. Yet we cannot stop. Our failure is born of selfishness (to hell with our grandchildren) and a failure of imagination. And the worst offenders are the Americans, who make up 4% of the world's population but produce nearly a quarter of its greenhouse gases. They must provide leadership. President Bush has a chance to prove himself a leader who will be remembered long after the average president by doing just that.

Richard Smith *editor, BMJ*

1 Ghazi P. Talks on climate change collapse in acrimony. *BMJ* 2000;321:1367.
2 Intergovernmental Panel on Climate Change. *Special report on emission scenarios*. Geneva: IPCC, 2001.
3 Haines A, McMichael T, Anderson R, Houghton J. Fossil fuels, transport, and public health. *BMJ* 2000;321:1168-9.
4 Grubb M. Greenhouse emissions and the changing climate. *BMJ* 2000;321:1169-70.
5 Harries JE, Brindley HE, Sagoo PJ, Batges RJ. Increases in greenhouse forcing inferred from the outgoing longwave radiation spectra of the earth in 1970 and 1997. *Nature* 2001;410:355-7.

BMJ 2001;322:690

We ask all editorial writers to sign a declaration of competing interests (bmj.com/guides/confli.shtml#aut). We print the interests only when there are some. When none are shown, the authors have ticked the "None declared" box.